Strategic Plan
August 2, 2004

Regional Partnership

Health Planning Region I

1. Regional Partnership Mission, Values Statement, and Strategic Direction

Mission

It is the mission of the Health Planning Region I (HPR I):

- to provide flexible, comprehensive, outcome driven services for all population groups;
- to honor consumer and family caregiver collaboration at all levels; and
- to ensure streamlined access to services and funding.

Values Statement

The following core values provide the foundation for Health Planning Region I's mission and strategic direction:

- customer focus - the Region is committed to serving the community by considering first the needs of the individuals we serve.
- quality service – the Region seeks to uphold key clinical principles and is committed to excellence, professionalism, and continuous improvement, while remaining focused on outcomes.
- partnership and collaboration – the Region strives to create opportunities for partnerships, encourages teamwork, and communicates openly.
- stewardship – the Region attempts to use the Commonwealth's resources in the most effective and efficient manner.

Strategic Direction

The Region identified the following strategic direction:

- Create sustainable diversion alternatives for all consumers with co-occurring disorders, mental retardation and substance abuse through utilization management and regional development of alternative, specialized programs. Examples would include primary acute care diversion for short term psychiatric hospitalization and crisis stabilization options for individuals with co-occurring disorders (Mental Health/Substance Abuse (MH/SA) and Mental Health/Mental Retardation (MH/MR).
- Expand community capacity to support individuals in need of long term supports for medications, case management, rehabilitation and housing.
- Improve regional coordination of children's services.
- Ensure the resources of Western State Hospital (WSH) for the specialized, long term care for adults in need of this service and the acute care of those who cannot be served in community settings.
- Target new resources and efforts toward individuals identified on the extraordinary barriers list.
- Address needs specific to HPR I and identified by the Olmstead Task Force.

2. Overview of the Regional Partnership Strategic Plan

This Regional Partnership Strategic Plan describes how Health Planning Region I will move forward to achieve the vision of a community-based system of public mental health, mental retardation, and substance abuse services.

The report closely follows the "Guidance for Regional Partnership Strategic Plans and Recommendations" prepared by the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS). As directed, the report is the result of a process encompassing ongoing-regionally-based planning, communication with key stakeholders, and a comprehensive assessment of the current system of care. This process began in 2003 with stakeholder forums and regional assessments.

A. Recognition of Regional Partnership (Reinvestment) accomplishments

Health Planning Region I has achieved a number of successes:

- Working together, the region discharged 35 people from Western State Hospital to the community thus closing a ward at WSH allowing the transfer of $897,000 in FY04 and $1.4 million in FY05 from WSH to the Community Service Boards (CSBs). HPR I is currently managing over six million dollars dedicated to 180 Discharge Assistance Projects (DAP) consumers (this is approximately one-half of the DAP consumers statewide). This success is demonstrated with low recidivism rates.

- The region has maintained approximately $190,000 of Reinvestment money for bed purchase should Western State's census get to a point that an individual on a TDO who otherwise would be appropriate for admission cannot be admitted. The Region spent over $108,000 in FY 04 with 44 individuals being served.

- An outgrowth of the restructuring process was the development of a Utilization Management Committee comprised of staff from Community Service Boards (CSBs), Western State Hospital and private acute care facilities. This committee developed a plan for the use of private beds in the region. Another committee worked with a part-time Utilization Management Coordinator in the development of a protocol for hospitalization of the region's consumers if a bed is not available at Western State Hospital.

- A utilization management team comprised of mental health directors from the region was formed to manage acute care diversion and Western State Hospital census issues.

- HPR I has successfully operated the New Hope Detox program (Valley CSB) and the Boxwood Treatment Program (RRCSB) for over 17 years for individuals with chemical dependence.

- HPR I has virtually eliminated primary substance abuse admissions to Western State Hospital with a successful facility diversion program managed in the region.

- A financing commitment from Rural Development for $3.2 million to replace the Boxwood Treatment Center facility.

B. Structure of the process

Rather than create additional workgroups for preparing this strategic plan, Region I maximized the use of existing committees. The Utilization Management Committee, the SA Diversion workgroup, the CSB Liaison Group, and the Substance Abuse Directors provided input for this project. The monthly meetings of Health Planning Region I have provided a forum for discussion of ongoing challenges and opportunities for the region. The Region has worked collaboratively and actively solicited the suggestions of key constituents and stakeholders regarding potential areas for improvement and strategies for the future. Each participating CSB's Board of Directors has reviewed and provided valuable feedback to this strategic plan and incorporated its components into local planning activities.

See Item 7 for a list of the participants.

3. Summary of the Regional Partnership's Strategic Assessment

A. Constituent and consumer expectations

Beginning in 2003, with stakeholder forums, Health Planning Region I has successfully solicited the input of consumers, advocacy groups and family members. In addition, a public forum was conducted on July 16, 2004, in Culpeper, Virginia to allow stakeholders to respond to the draft strategic plan and participate in meaningful dialogue about the issues and opportunities for this region.

B. Regional Partnership SWOT Analysis

Internal Strengths	**Internal Weaknesses**	**External Opportunities**	**External Threats**
History of regional success in terms of downsizing WSH via discharge projects that have been both funded and not.	Gap between intensity of day program structure and PSR opportunities between WSH and CSBs. This is complicated by relatively small size of region's CSBs.	To utilize WSH's Psychosocial Rehabilitation/ Recovery (PSR) resources more fully for individuals in communities.	Inflationary pressures and staffing standards at WSH and at CSBs greatly limit opportunities for further reinvestment.
Boxwood Treatment Center and New Hope Detox represent long term regional collaboration	Number of supervised residential placements and the capacity to fully individualize the intensity and nature of that supervision is still lacking. Absence of Programs of Assertive Community Treatment (PACT) teams for all CSBs contributes to this.	Better screening of consumers in local jails in need of inpatient forensic services.	Affordable and accessible housing. The need for more available Section 8 funds was noted in the public forum.
Stakeholder participation	Options with which to respond to during crisis remain limited. Crisis stabilization/respite options for MH population, crisis stabilization options for MR, crisis stabilization for MH/SA, particularly SA issues pertaining to women. Only limited private bed purchase funds and reductions in region's private psychiatric beds are all factors. Existing private beds are impacted by bed purchase programs and other demands from other regions.		Program development limited by funding only for post-discharged consumers. Needs are more broad-based than this.

Internal Strengths	Internal Weaknesses	External Opportunities	External Threats
Creative development of an acute care diversion program in the absence of diversion funding	Ever increasing medication costs and CSB reliance on indigent programs sponsored by Pharmaceutical companies creates a dependence and vulnerability upon agents beyond our control		Lack of community-based crisis-stabilization services, all disabilities and ages.
Creative collaboration with mental health and mental retardation state facilities.	Financial support provisions for NGRI patients being placed on Conditional Release do not cover the costs of maintaining supervision and treatment for these individuals.		Lack of infrastructure and access to ancillary services.
	Mis-alignment of DMAS reimbursement with needed services as well as increasing numbers of individuals not eligible for Medicaid or Medicare pose problems in service alignment and capacity for CSBs		Medicaid reimbursement rates
	Program loss of private beds in region, as well as impact on regional provider beds by WSH in other regions, especially Northern Virginia		Waiting list for waiver slots and demand this places on private providers.
	A concern for lack of access to outpatient psychiatrists at CSB level was voiced at stakeholder meeting.		Lack of plan for programs for individuals without Medicaid
	Lack of training and education for law enforcement regarding mental illness was voiced at stakeholder meeting.		Lack of financial incentives for collaboration
	Need for increased Geriatric MR services.		Funding for children's services
	Need for qualitative analysis of the private providers receiving diversion funds		Stable source for indigent drugs

C. Description of any emerging external political, economic, social, and technological trends.

Health Planning Region I encompasses seven Community Service Boards with a 2000 census of 1,019,548. In addition, HPR I includes the CVCSB/Lynchburg area. Some Region I participants acknowledged the lack of a consistent consensus on how to address Regional mental health care issues because the Region varies greatly and

there are differing local needs. It was argued by some that the Department of Mental Health, Mental Retardation and Substance Abuse Services' current delineation of boundaries for regional activity may need to be reviewed based on the Commonwealth's changing demographics. Likewise, in terms of political trends, Region I participants advocated the need for a distribution of new state resources that promote ongoing political support throughout the Region.

The Region recognizes its changing demographics as the country's overall diversity increases. According to the U.S. Bureau of the Census, Population Division, Virginia is expected to gain 605,000 people through international migration between 1995 and 2025, placing it eighth largest among the net international migration gains among the 50 states and the District of Columbia.[1] A review of population trends for the City of Harrisonburg (population 42,865 as of January 2003) provides a snapshot of cultural and social needs of one of the Region's Community Service Boards (Harrisonburg/Rockingham County). In 2000, the Hispanic percentage of Harrisonburg's population (8.8%) was almost twice as high as that of the state of Virginia (4.7%). Recent data on English as a Second Language (ESL) enrollment from Harrisonburg City Public Schools indicates that 31 percent of all students in the city's six schools are enrolled in ESL programs, speaking 38 different languages representing 52 foreign countries.[2] As strategic directions are determined, it is imperative that this diversity be addressed.

The region includes rural areas, some of which have limited or no private psychiatric services. The shortage of specialists is critical in rural areas where the need for such services may not warrant a full-time practitioner.

Recognizing Loudon County's extremely high growth rate of 32 percent, followed by two other Northern Virginia counties, Spotsylvania and Stafford, Health Planning Region I and Western State Hospital will geographically be in position to experience pressure as Northern Virginia's growth spills into the area. Of particular concern is the loss of private psychiatric beds in the Northern Virginia area. If psychiatric beds in the eastern Northern Virginia region and at Alexandria and Woodbridge's Potomac hospitals are no longer available, the Northern Virginia region will have greater difficulty finding psychiatric beds for individuals needing intensive crisis stabilization.

The current economic situation has resulted in financial cost containment efforts in Medicare and Medicaid which leave some individuals uncovered and ineligible, but still in need of CSB and related services. In addition, the cost of new medications and focus on "recovery" and "the individual" both of which are consistent with the

[1] "Virginia's Population Projections." U.S. Bureau of the Census, Population Division, Population Paper Listing #47, Population Electronic Product #45. June 7, 2004.
www.census.gov/population/projections/state/9525rank/vaprsrel.txt.

[2] Harrisonburg Department of Planning and Community Development 2004 Comprehensive Plan, Chapter 3, Planning Context.

standard of care, are more expensive than in the past. Basically, the components of the current standard of practice are more expensive and funding has not kept pace with these changes.

It is anticipated that the need for a wide spectrum of services provided by Health Planning Region I will continue to expand in the coming years. The proportion of Virginia's population classified as elderly is expected to increase from 11.1 percent in 1995 to 17.9 percent in 2025.[1] As the population of the region ages, those individuals who have been diagnosed with a mental illness, mental retardation or substance abuse, will more likely have physical conditions in addition to their mental health needs. HPR I must be prepared to provide a comprehensive array of specialized prevention and treatment services and supports for elderly persons with mental and substance use disorders.

Technological advancements may also impact the delivery of health care. Advances in assistive technology devices for vision, hearing, mobility and orthopedic impairments will be affected. A report from the National Center for Health Statistics found that the use of assistive devices has increased dramatically over the past decade, in part due to the aging of the population, but also due to technological advances.[3] Technological advancements could likely result in an increased survival rate as well as improved means for identifying mental illness, mental retardation and substance abuse. It is imperative that HPR I be poised to provide a myriad of services in a manner that is in keeping with the Region's stated mission – flexible, comprehensive, and outcome driven.

D. Opportunities for achieving operational efficiencies and cost savings.

The availability of resources available to Region Health Planning I has not kept pace with the growing health care needs and expectations for services. In order to responsibly bridge this gap for the benefit of the citizens served, providers will need to explore opportunities for achieving operational efficiencies and cost savings through resource sharing.

Health Planning Region I identified the following possible opportunities for resource sharing:

- Management Information Systems
- Data management – need to have more data driven planning
- Quality Assurance
- Procurement
- Psycho-social Rehabilitation

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[3] "Trends and Differential Use of Assistive Technology Devices: United States", 1994. National Center for Health Statistics. June 6, 2004.
www/cdc.gov/nchs/pressroom/97facts/dsable.htm.

- Enhance partnership opportunities with colleges and universities in order that possible student practicum and/or internship programs are utilized to the benefit of students and providers.

4. Critical Issues Facing the Region

A. While it is difficult to prioritize the critical issues facing HPR I, given that all seem of equal concern, the following represents the most critical issues, in priority order.

1. Access to acute care psychiatric beds

Health Planning Region I identified this as critical from the beginning of their partnership. The Region collaborated with all private providers in developing a regional response and developed a program without any ongoing diversion funds. The region also participated in a forum hosted by Fauquier Hospital on the critical need for acute care beds in Health Planning Region I which involved local officials and the DMHMRSAS Commissioner. It was noted at the July 16, 2004, public forum that reinvestment is predicated on private provider capacity and there is currently a declining number of private sector inpatient psychiatric beds. This is of particular concern for children and adolescents. If beds are purchased with reinvestment funds the private hospital may in turn not serve some uninsured or indigent patients who would then need to be admitted at Western State. For the private hospitals, uninsured patients pose a significant challenge to their continuing operation.

2. Need for Crisis Stabilization programs and short term respite care.

Crisis Stabilization programs have worked effectively in mental health systems nationwide and in Virginia, e.g. the recent Times-Dispatch article describing the Region IV program. Such programs can respond cost effectively to individuals who are not so ill as to need inpatient care or whose acute situation can be managed by the support and safety of a controlled environment. Such a program in Region I would accomplish two primary tasks. First, many individuals in crisis would have an alternative to an expensive inpatient hospitalization. Second, individuals with severe longstanding mental illnesses could access the program for several days of respite, restoration of medication regimens, and more intensive staff support. Such a stay can prevent further decline and would result in a better quality of life by avoiding more severe symptoms and behavioral risks than would require an inpatient stay. While it is expected that such a program would reduce the use of inpatient bed days, it is as importantly an addition of an important service currently lacking in Region I.

3. Need for improved collaboration for regional children's services.

The Comprehensive Services Act has improved communication among the various agencies providing services to children, but it has also reduced the role of the Community Services Board as the entry point for children in need of public mental health services in Virginia. In many localities, case managers within the schools, at DSS offices and in court services units are much more controlling of the process of securing psychiatric services for children, often with little input from CSB staff. The result has frequently been inappropriate placements, ineffective interventions and skyrocketing costs. The competing pressures among the agencies can cause the placement decision process to become politicized, and the credibility of opinions of CSB mental health professionals, who may be viewed as simply another vendor, is often discounted in lieu of other factors influencing the process.

4. Expansion of community capacity (availability of PACT programs)

PACTs serve a three-fold purpose. First, they could prevent admission to Western State that occur now due to the lack or inadequacy of these supports. Second, they will provide the necessary supports to enable improved discharge planning for individuals currently in the hospital who require a higher level of community support than is currently available. Third, they will allow for decreased length of stays for individuals who are appropriately admitted for state hospital services.

5. Possible closure of current Boxwood Facility

Since 1985 the Boxwood Treatment Center, centrally located in Culpeper County, has been a stable treatment alternative for the indigent who live within the thirty-five Virginia cities and counties served. It has offered a proven 28-day treatment program to over 5,800 individuals. The facility was never designed for the twenty-four hour, seven day a week fully occupied operation. The facility fails to meet basic life safety concerns such as an integrated fire alarm system and intercom. In addition, there are no handicapped accessible bathrooms in the program. Without support, closure in the near future is eminent.

6. Appropriate use of WSH and CCCA as well as Central Virginia Training Center through effective utilization management

Since the beginning of the Reinvestment Initiative, Region I's Mental Health Directors have worked collaboratively. They will continue to make recommendations to the Regional Executive Directors

7. **Boxwood and New Hope program expansion capability to respond to crisis stabilization needs**

   Providing regional crisis stabilization services through enhanced efforts at New Hope and Boxwood provide a viable program alternative for individuals with co-occurring disorders.

5. Strategic Goals, Objectives and Strategies

A. Strategic goals, objectives and action steps proposed by the Regional Partnership

Goal #1 – Address the regional critical need for acute care psychiatric beds in the private sector.

Objective - Identify funding to allow for regional purchase of acute care services.

Action Steps:

a. Target reinvestment funding sufficient to purchase short term treatment for commitments when Western State Hospital is full.
b. Manage acute care regionally through an active utilization management committee in collaboration with private providers.
c. Work towards regional pilot projects where the goal is the diversion of all Western admissions.
d. Expand contracting ability for acute care services to facilities beyond the Health Planning Region.
e. Reserve admissions to Western State Hospital to individuals needing longer term care while ensuring sufficient resources at Western in order to provide acute care services for those who cannot be served in community settings.

Objective - Develop process for evaluating the quality of care provided by private providers receiving reinvestment funding.

Action Steps:

a. Solicit input from private providers on the process for evaluating services.
b. Formulate committee of CSB quality managers to determine appropriateness, access, outcome and general satisfaction with care provided.

Goal #2 – Develop Crisis Stabilization Program to better address needs of individuals with co-occurring needs related to mental health and substance abuse.

Objective - To address the need for support for individuals with mental retardation who experience short term and extreme behavioral challenges.

Action steps:

a. Work with the new director at the Central Virginia Training Center to consider recommendations of a committee comprised of staff from Western State Hospital, Central Virginia Training Center, and Central Virginia Community Services.
b. Pilot a recommended program which would establish a special intervention team to allow stabilization to occur in the home residence including consultation, temporary staff support, and follow up.
c. Establish a crisis stabilization unit at Central Virginia Training Center to provide intervention for individuals who cannot safely be maintained in their own home due to risk of harm to self or others.

Objective – To address the needs of individuals in crisis who require intensive services and avoid inappropriate hospitalization at Western State Hospital.

Action Steps:

a. Utilize new regional State general funds to enhance existing service offerings at both New Hope and Boxwood treatment programs to improve capacity to accept more challenging referrals.
b. Target some regional funding to provide additional bed purchase capability specifically for SA issues and detox services to supplement funds in the existing SA diversion project.
c. Get consultation and additional staff training for New Hope and Boxwood to increase staff knowledge and expertise in the effective management and treatment of individuals with co-occurring disorders.
d. Explore other avenues of support including fee generating capability of crisis stabilization services.
e. Have regional Utilization Management Team track consumers served through these activities collecting relevant data to evaluate outcomes.

Goal #3 – Improve collaboration for regional children's services.

Objective - CSBs to serve as the sole entry point into publicly-funded mental health care.

Action Steps:

a. The cases of all children accessing public funds for mental health care must be managed by CSB case managers.
b. Assessment of the suitability of outpatient care must be made by CSB staff prior to the implementation of any more intensive, publicly-funded intervention.
c. Access to CCCA, including for 10-day evaluations, made available only to those deemed appropriate for that service by CSB staff, with justification for not using less intensive, community-based services provided.

Objective – Strengthen resources within the CSB to solidify its position as the children's mental health authority.

Action Steps:

a. Legitimize the role of the CSB case manager for discharge planning of CCCA patients through service funding to enable adequate staffing and involvement in the planning process.
b. Develop consultative liaison, perhaps through video-conferencing, with CCCA to allow CSBs access to the expertise of child psychiatrists, both for cases shared by CCCA and the CSB as well as for cases being maintained and receiving continuing care in the community.
c. Improve understanding of community resources and of the factors affecting transition from adolescent to adult services, such as access to entitlements, by providing training to CCCA staff in the community.

Goal #4 – Provide services and supports outside of traditional catchment area boundaries.

Objective – To provide a PACT team for every CSB currently without such team.

Action steps:

a. Allocate funding to new teams which will be comprised of case management, residential support and psychiatric nursing staff with specific caseloads targeted to support stable community placement.
b. These teams will support many of the individuals identified in priority DAP plans for FY 05.
c. These collaborations will focus resources on improving responsiveness to individuals whose needs include case management, medications management, day rehabilitation, transportation and housing. .

Goal #5 – Replace Boxwood facility.

Objective - Using previously completed feasibility report, prepare a financial analysis for debt service to construct a replacement facility using designs already completed.

Action Steps:

a. Survey participating CSBs to assess willingness to increase per diem payments to service long term debt.
b. Present feasibility study and financial analysis to potential financing sources.
c. Secure financing and adopt appropriate borrowing resolutions from local governments of the RRCSB.
d. Complete architectural development and bidding.
e. List existing Boxwood property for sale.
f. Begin construction for replacement facility.

6. Regional Partnership Recommendations for State-Level Action

A. Describe any regional recommendations for state-level action or actions.

1. Statewide Medicaid rates for core CSB service needs to be evaluated and raised to be more reflective of the actual cost of providing services.
2. State funding needs to address the needs of individuals who do not qualify for Medicaid.
3. Pharmaceuticals represent an ever increasing percentage of health care budgets in Health Planning Region I. The rising cost of medications must be addressed.
4. Legislation should be pursued to address needed training and education for sheriffs and magistrates regarding individuals with Temporary Detention Orders, etc.
5. Re-evaluate the current regional make-up in light of marked changes in population, demographics, and urban/rural balance over the past 25 years.

B. Assessment of the region's readiness for and potential viability of significant restructuring of state facility and community services within the region.

Health Planning Region I will continue to strive for collaborative efforts which can better serve the population needs of the region.

7. Attachments

Listing of Regional Partnership Participants

Central Virginia CSB
Rappahannock-Rapidan CSB
Northwestern CSB
Rappahannock Area CSB
Region Ten CSB
Rockbridge Area CSB
Harrisonburg/Rockingham CSB
Western State Hospital
Augusta Medical Center
Kenmore Clubhouse – RACSB
NAMI – Fredericksburg
Snowden of Fredericksburg
Fauquier Hospital
Mental Health Association of Fauquier County
ARC of Central Virginia
ARC of Piedmont
University of Virginia Hospital
ARC of Rappahannock
Visions Clubhouse – RRCSB
Western State Advisory Board
Central Health – VA Baptist Hospital
Rockingham Memorial Hospital
DMHMRSAS